STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151329	A. BUILDING 00 B. WING	09/08/2011

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MARGARET MARY COMMUNITY HOSPITAL INC	321 MITCHELL AVE BATESVILLE, IN47006

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S0000	This visit was for a standard licensure survey. Facility Number: 004718 Survey Date: 9-6-11/9-8-11 Surveyors: Jack I. Cohen, MHA Medical Surveyor John Lee, RN Public Health Nurse Surveyor Albert Daeger Medical Surveyor QA: claughlin 09/22/11	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0406	410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review, the hospital failed to include 3 services provided by a contractor as part of its comprehensive quality assessment and performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include the contracted services of biohazardous waste, blood bank and EEG (electroencephalography) in its QAPI program. 2. On 9-8-11 at 1:00 pm, employee #A5 was requested to provide the above documentation and none was provided prior to exit.	S0406	On October 1, 2011, the Hospital Performance Improvement Plan was revised to include monitors and reporting for Biohazard Waste, Blood Bank and EEG. Housekeeping - Biohazard Waste will monitor timeliness of biohazard trash pick up. All Housekeeping staff were inserviced on September 30, 2011 regarding biohazard waste PI. Maintenance Staff were inserviced on Biohazard Waste PI on October 5, 2011. The Daily Stericycle Room Inspection Log was revised to include this PI. The Hazardous Materials and Waste Management Plan was reviewed.Laboratory - Blood Bank will monitor number of blood products passing Hoxworth QA requirements. The Blood Bank Supervisor was inserviced October 3, 2011, regarding Blood Bank PI. Cardiopulmonary - EEG will monitor Transtelephonic EEG Tracing Artifact from Receiver to Sender. The EEG Technician	10/01/2011

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			was inserviced on October 5, 2011 regarding the EEG PI.All monitors will be reported through the established hospital wide system to include Medical Staff and Board of Directors.The Director of Quality Services and designated Managers will be responsible for compliance in the future and that all services have a PI plan in place.Supporting documentation is attached.	
S0418	410 IAC 15-1.4-2(b)(1)(2) (b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows: (1) The action shall be documented. (2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care. Based on document review, the hospital failed to take appropriate action to address an opportunity for improvement found through the quality assessment and performance improvement(QAPI) program in 1 instance. Findings: 1. Review of a document entitled [PERFORMANCE IMPROVEMENT SUMMARY-ACTION PLAN (S-A), indicated for the pharmacy, for the period	S0418	On September 9, 2011, a revision was made to the Meditech documentation that provides the creatinine clearance calculation levels on all patients placed on Levaquin. This change will assure compliance of the QI indicator. Pharmacy will monitor monthly the creatinine clearance calculations on all Levaquin patients. All Pharmacy staff were inserviced on September 9, 2011, regarding creatinine clearnace PI. The PI Summary Action Plan was was revised to include this PI monitor.All monitors will be	09/09/2011

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	January, 2010 through June, 2011, an indicator of creatinine clearance averaged 77%, with a standard of 100%. Further review indicated the action taken for the entire 18 month period was to continue monitoring. 2. Since there were no specific actions taken other than monitoring, and since the outcome for the last 6 months averaged 75%, the action taken was not effective.		reported through the established hospital wide system to include Medical Staff and Board of Directors.The Director of Pharmacy will be responsible for compliance in the future.Supporting documentation is attached.	
S0554	410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on document review and interview, the hospital failed to follow its policy for the concentration testing of CIDEX OPA Solution. Findings: 1. Review of a hospital policy entitled CIDEX OPA SOLUTION indicated the CIDEX OPA Solution test strips will be utilized prior to each use to verify Minimum Effective Concentration (MEC) of CIDEX OPA Solution.	S0554	On September 8, 2011, the Ultrasound Transducer Cleaning Procedure Policy was revised to include testing of the germicidal agent solution prior to each use. Radiology Ultrasound Staff were inserviced on September 9, 2011 on procedure changes. Radiology Manager revised PI Summary Action Plan to include monthly monitoring of germicidal agent solution testing prior to each use and documented on Cidex OPA Solutions Log Sheet.All monitors will be reported through the established hospital wide system to include Medical Staff and Board of	09/08/2011

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	2. On 9-6-11 at 3:20 pm, upon interview, a hospital radiology ultrasound staff member indicated the Cidex was tested only once per day if the solution was used more than once per day.		Directors.The Radiology Manager be responsible for compliance in the future.Supporting documentation is attached.	
S0612	410 IAC 15-1.5-2(f)(3)(D)(xi) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (xi) A program of linen management for personnel involved in linen handling. Based on document review and observation, the hospital failed to follow its policy to store clean linen in 1 instance. Findings: 1. Review of a hospital policy entitled LINEN HANDLING indicated clean linen is stored in the clean storage room in a closed cart or covered shelving until used.	S0612	On September 30, 2011, a procedure change was made in laundry storage areas to include the covering of laundry carts that have clean linen stored on them. The Laundry Staff were inserviced on September 30, 2011 on proper storage of linen. The Support Services Director revised PI Summary Action Plan to include monthly monitoring of proper storage of linen. The Laundry Staff reviewed the Linen Handling policy.All monitors will be reported	09/30/2011

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	2. On 9-6-11 at 2:30 pm in the presence of employees #A1, #A3, #A4 and #A5, it was observed in the laundry storage area that there were 2 carts, each containing clean linen and the carts were uncovered.		through the established hospital wide system to include Medical Staff and Board of Directors.The Support Services Director be responsible for compliance in the future.Supporting documentation is attached.	

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S0912	410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following: (2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital. Based on document review, the facility failed to ensure that nursing personnel followed established nursing policy/procedure in all settings in which nursing care is provided in the hospital for 2 of 2 newborn medical records (MR)	S0912	On September 28, 2011, the OB Department Manager made changes in Meditech documentation interventions to facilitate compliance. OB Nursing Staff were inserviced on documentation requirements on September 28, 2011. OB	09/28/2011

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	reviewed (patient #8 & 9). Findings include; 1. Review of policy/procedure Unit Specific - Maternity Services Initial Newborn Care in Delivery Room indicated the following: "12. Vital Signs - HR, RR, temp, SATS on admission and every 30 minutes until stable for 2 hours." This policy/procedure was last reviewed/revised on 04-10. 2. Review of patient #8's MR indicated the patient was admitted on 07-26-11 at 1654 hours and HR, RR, temp, SATS were done at 1930 and 2300 hours. 3. Review of patient #9's MR indicated the patient was admitted on 07-28-11 at 0628 hours and HR, RR, temp, SATS were done at 0630 and 0930 hours.		Manager revised PI Summary Action Action Plan to include monthly monitoring of associated documentation. The Maternity Services Initial Newborn Care in the Delivery Room policy was reviewed.All monitors will be reported through the established hospital wide system to include Medical Staff and Board of Directors.The OB Manager be responsible for compliance in the future.Supporting documentation is attached.	

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S1150	410 IAC 15-1.5-8 (c)(9) (c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following: (9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department. Based on observation, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 2 instances. Findings: 1. On 9-7-11 at 9:30 am, in the presence of employees #A1, #A3 and #A4, it was observed in a housekeeping closet of the Outpatient Rehabilitation Center that there was a flexible hose connected to a water spigot with no backflow preventor. 2. On 9-7-11 at 9:50 am, in the presence of employees #A1, #A3 and #A4, it was observed in the ADL Bathroom of the Outpatient Rehabilitation Center that there was a flexible hose connected to a	S1150	On September 8, 2011, a backflow preventor was installed in the Housekeeping Closet and ADL Bathroom of the Outpatient Rehabilitation Center. The Maintenance Department checked all Housekeeping Closets throughout the facility. The Maintenance Department will assure backflow prevention devices are installed appropriately and will add this task to the Enviornmental Rounds checklist. Maintenance Staff were inserviced on appropriate placement of backflow prevention devices on September 8, 2011. Plant Operations Manager revised PI Summary Action Action Plan to include monthly monitoring of backflow preventors in Outpatient Rehabilitation Center.All monitors will be reported through the established hospital wide system to include Medical Staff and Board of Directors.The Plant	09/08/2011

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	water spigot with no backflow preventor.		Operations Manager will be responsible for compliance in the future.Supporting documentation is attached.	
S1164	410 IAC 15-1.5-8(d)(2)(B) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (B) There shall be evidence of preventive maintenance on all equipment. Based on document review, the hospital failed to follow the manufacturer's recommendation for weekly maintenance of 1 piece of equipment. Findings: 1. Review of the Operator's Manual for maintenance of a floor scrubbing machine indicated there should be weekly procedure including, but not limited to, battery charging, squeegee cleaning brush/pad cleaning, tank and vacuum grid with float cleaning, and cover gasket check, screw and nut tightening check, brush pad holder motor carbon brushy check or replacement and vacuum system motor carbon brush check or replacement. 2. Review of a hospital document entitled	S1164	On September 29, 2011, a the Floor Scrubber Maintenance Log was changed to include the daily and weekly maintenance requirements per manfucaturer's recommendations. Housekeeping Staff were inserviced on September 29, 2011, and educated on appropriate manfucaturer's recommendations. Support Services Director revised PI Summary Action Action Plan to include monthly monitoring of completion of required maintenance.All monitors will be reported through the established hopsital wide system to include Medical Staff and Board of Directors.The Support Services Director be responsible for compliance in the future.Supporting documentation is attached.	09/29/2011

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	Room Inspection, dated September, 2010, indicated there was a monthly check only of a floor scrubber which included checking for general appearance, proper operation, and electrical leakage. 3. The Room Inspection document indicated this was a monthly document, which did not comply with the manufacturer's recommendation of weekly checks.			
S1168	410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained. Based on document review and interview, the hospital failed to keep a discharge log based on manufacturer recommendation for 4 of 4 defibrillators. Findings: 1. Review of the HeartStart XL Defibrillator/Monitor manual indicated the manufacturer recommended to perform a "Shift/System" Check every shift to verify that the HeartStart XL is functioning properly and to ensure that necessary supplies and accessories are	S1168	On September 8, 2011, the Crash Cart & Defibrillator Check Policy was revised to include checking crash carts every shift during operational hours. All clinical areas received a memo dated Spetember 29, 2011, regarding crash cart check requirements. Med-Surg and OB will create a PI Summary Action Plan to include monthly monitoring. All monitors will be reported through the established hospital wide system to include Medical Staff and Board of Directors. The Clinical Area Managers will be responsible for compliance in the future. Cardiopulmonary,	09/08/2011

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	present and ready for use. 2. On 9-6-11 at 3:40 pm, upon interview, departmental staff indicated the department was open on the day shift Monday through Friday, but the defibrillator was accessible to hospital personnel 24 hours a day, seven days a week. 3. Review of a document entitled MMCH Daily Crash Cart/Defibrillator Check indicated the defibrillator located in in the Cardio-Pulmonary department was checked once per day, Monday through Friday. Thus the defibrillator was not checked once per shift. 4. During the facility tour on 09-06-11 at 1335 hours of the Inpatient Medical/Surgical unit a Phillips defibrillator was observed and the defibrillator discharge log indicated the Phillips defibrillator was discharged once per day. 5. During the facility tour on 09-06-11 at 1445 hours of the Inpatient Obstetrical unit a Phillips defibrillator was observed and the defibrillator discharge log indicated the Phillips defibrillator was discharged once per day. 6. Review of a hospital document entitled		Med-Surg and OB Nursing Staff were inserviced on the revised policy on October 5, 2011. On September 30, 2011, the Annual Automated External Defibrillator Check Sheet was revised to include checking specific AED supplies monthly. Cardiopulmonary Manager will create a PI Summary Action Plan to include monthly monitoring. All monitors will be reported through the established hospital wide system to include Medical Staff and Board of Directors. The Cardiopulmonary Manager will be responsible for compliance in the future.On October 5, 2011, the Cardiopulmonary Staff were inserviced on the revised Annual Automated External Defibrillator Check Sheet. On September 29, the Nursing Supervisors were inserviced on revised Annual Automated External Defibrillator Check Sheet.Supporting documentation is attached.	

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	Crash Cart & Defibrillator Check, indicated AED [(Automated External Defibrillator)] supplies will be checked on a monthly basis. 7. Review of a document entitled Annual Automated External Defibrillator Check Sheet indicated for the AED located in the Main Lobby, there was no documentation for it being checked monthly for supplies.			